Annual Report to

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

on

Deaths Reported and Facility Compliance with Restraints and Seclusion

as originally required by SL 2000-129, Section 3(b), 5(b) and 6(b)
and as amended by SL 2003-58, Sections 1-4

Submitted by
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
and Division of Facility Services
Department of Health and Human Services

August 25, 2004

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INTRODUCTION

Section 3(b), 5(b) and 6(b) of Session Law 2000-129 (HB 1520), as amended by Sections 1-4 of Session Law 2003-58 (HB 80), requires the Department of Health and Human Services to report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services on the following for the immediately preceding fiscal year:

- The total number of facilities that reported deaths under G.S. 122C-31, G.S. 131D-10.6, and G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to these statutes, and the number found by the investigation to be related to the use of restraint or seclusion.
- The level of compliance of certain facilities with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall include areas of highest and lowest levels of compliance.

Outlined in the succeeding pages is a compilation of the data provided by these facilities in addition to deficiency information gleaned from monitoring reports, surveys and investigations conducted by Department staff. **This data covers the period of July 1, 2003 through June 30, 2004.**

DEATHS REPORTED

Session Law 2000-129 amended G.S. 122C-31, 131D-10.6B and 131D-34.1 by requiring certain facilities to notify the Department of Health and Human Services of any death of a consumer:

- Occurring within seven days of use of physical restraint or physical hold; or
- Resulting from violence, accident, suicide or homicide.

10A NCAC 26C Section .0300 implement the death reporting requirements of these laws and provide specific instructions to facilities for reporting deaths.

- **Facilities licensed** in accordance with G.S. 122C, Article 2, **State facilities** operating in accordance with G.S. 122C Article 4, Part 5 and **inpatient psychiatric units** of hospitals licensed under G.S. 131E shall report client deaths to the **Division of Facility Services**.
- **Facilities not licensed** in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5 shall report client deaths to the **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services**.

All deaths reported to the Department are screened to determine if an investigation is warranted. The primary purpose of the screening and any subsequent investigation is to determine if the facility was culpable in the consumer's death. For purposes of this report, the outcome of the investigation is limited to whether the death occurred as a result of restraint, physical hold, or seclusion.

The following seven tables depict each facility that reported one or more deaths for the time period beginning July 1, 2003 and ending June 30, 2004. Each table identifies the number of deaths reported and screened, deaths investigated and the number found by the investigation to be a result of the facility's use of physical restraint, physical hold, or seclusion. If a facility is not listed, a death was not reported to the Department.

DEATHS REPORTED BY PRIVATE FACILITIES

The first five tables provide data submitted by private facilities regarding deaths that were subject to the reporting requirements in G.S. 122C-31, 131D-10.6B and 131D-34.1, namely deaths that occurred within seven days of restraint, physical hold, or seclusion, or that were the result of violence, accident, suicide or homicide. These tables do not include deaths that were voluntarily reported to the Department that were the result of other causes. It should be noted that all deaths that were reported were screened and investigated when circumstances warranted it. Summary information about other deaths that were voluntarily reported to the Department are provided after each table.

Private Facilities: Licensed Assisted Living Facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Investigated and Death was due to Restraint/Hold[3]
Buncombe	George Town Family Care Home	1	1	
Burke	Longview Assisted Living	1	1	
Caldwell	Hilltop Rest Home	1	1	
Carteret	Diversicare of Newport	1	1	
Cleveland	Yelton's Health Care	1	1	
Craven	Christian Care of New Bern	1	1	
Davidson	The Oaks of Thomasville	1	1	
Durham	The Meadows of Oak Grove	1	1	
Forsyth	Kerner Ridge Assisted Living	1	1	
Gaston	Abingdon Place of Gastonia	1	1	
	Country Time Inn	1	1	
	Southhaven Assisted Living	2	2	
Guilford	Greensboro Manor	1	1	
Henderson	Carolina Village Care Center	1	1	
	Soundview Family Care Home	1	1	
	Valentine Family Care Home	1	1	
Iredell	Olin Village	1	1	
Johnston	Autumn Care	1	1	
Mecklenburg	Charlotte Square Assisted Living	3	3	
	New River Assisted Living	1	1	
	True Care Rest Home	1	1	
McDowell	Mountain View Care Center	1	1	
	Lake James Lodge	1	1	
	Fairview Assisted Living	1	1	
Northampton	Roanoke Valley Assisted Living	1	1	
Rockingham	WillaBerry Home	1	1	
Rutherford	Restwell Home	1	1	
Surry	Colonial Care	1	1	
	David's House	1	1	
	Ridge Crest Retirement Center	1	1	

Private Facilities: Licensed Assisted Living Facilities[1] (Continued)

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Investigated and Death was due to Restraint/Hold[3]
Wake	The Meadows of Garner	1	1	
	Oliver House	2	2	
Wayne	Newcomb Family Care	1	1	
Wilson	Diversicare Assisted Living	1	1	
Total		**38**	**38**	**0**

NOTES:

1. There were 1,272 Licensed Assisted Living Facilities with a total of 39,029 of beds.
2. For licensed assisted living facilities, the investigation may begin with a review and inspection (as needed) by county DSS and/or involvement of law enforcement staff to determine the full extent of investigation needed.
3. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

A number of licensed assisted living facilities voluntarily reported deaths that were not subject to G.S. 131D-34.1. For the period beginning July 1, 2003 and ending June 30, 2004, these facilities reported 53 deaths. Seventeen of these were investigated. None of these deaths were due to restraint or hold. These numbers were not included in the above table.

Private Facilities: Group Homes, Outpatient and Day Treatment facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Alexander	Foothills MH/DD/SAS	1	0	
Anson	Sandhills Center-Anson Unit	1	0	
Avery	New River Behavioral Healthcare	1	0	
Brunswick	Southeastern Mental Health	1	1	
Buncombe	Blue Ridge Center	1	0	
	Mountain Area Recovery Center	1	1	
	New Vistas Behavioral Health Services-Buncombe	4	0	
	Western Carolina Treatment Center	1	0	
Cabarrus	Piedmont Behavioral Health Center-Cabarrus	1	0	
Carteret	Neuse Center for MH/DD/SAS	1	0	
Caswell	Alamance Caswell MH/DD/SAS	1	1	
	Graham-Hopedale Road Facility-Burlington	1	0	
Catawba	McLeod Addictive Disease Center-Hickory	1	0	
	MH Services of Catawba County	1	0	
	MH Services of Catawba County/Counseling & SAS	1	1	
Cleveland	Cleveland Center-Pathways	1	0	
Columbus	HomeCare Management Corp	1	0	
Cumberland	CCMHC-Family Recovery Services	1	0	
	Cumberland County TASC	1	1	

Private Facilities: Group Homes, Outpatient and Day Treatment facilities[1] (Continued)

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
	Cumberland County-Rainbow Camp	1	0	
	Eutsler Residential Treatment Facility	1	0	
Currituck	Highway 158-Grandy/Albemarle MH Center	1	0	
Davie	Mocksville Outpatient Center (CenterPoint Human Services)	2	1	
Durham	The Durham Center	2	1	
Forsyth	Center Point Human Services	1	1	
Gaston	The Recovery Center	1	1	
Guilford	Bellemeade Center	1	0	
	The Guilford Center	1	0	
Iredell	DonLin Counseling Services	1	0	
	Ivey Lane Home	1	0	
Lincoln	Lincoln Counseling Center	1	0	
	Lincoln Recovery Center/Pathways	1	1	
Mecklenburg	LifeSpan Ventures	1	0	
Moore	Woodland House Psychosocial Rehabilitation	1	0	
Nash	Edgecomb-Nash	1	0	
New Hanover	New Hanover Treatment Center	1	0	
	Southeastern Center	1	0	
Orange	Northside Clinic	1	1	
Pitt	Government Circle	5	1	
Polk	CooperRiis, Inc.	1	1	
Randolph	Walker CenterProg.	2	0	
Robeson	Robeson SR MH/DD/SA	1	0	
Rockingham	Rockingham Area MH/DD/SAS	3	0	
Rowan	Alexander Youth Network	1	0	
	Piedmont Behavioral Health Center-Rowan	1	0	
Rutherford	The Rutherford Center	1	0	
Shelby	Cleveland Center-Pathways	1	0	
Stanly	Piedmont Behavioral Healthcare-Stanly Center	1	0	
Stokes	Center Point Human Services	1	0	
Surry	Crossroads Behavioral Healthcare-Elkin	2	0	
	Delphi Counseling Services	1	0	
	Peace Lily Development Inc	1	0	
Union	Piedmont Behavioral Healthcare-Union	1	0	
Wake	Southlight, Inc	1	0	
	Triumph, LLC	1	1	
Watauga	New River Behavioral Health Care	1	1	

Private Facilities: Group Homes, Outpatient and Day Treatment facilities[1] (Continued)

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Wilkes	New River Psychosocial Rehabilitation	1	0	
Total		**70**	**15**	**0**

NOTES:

1. There were 3,647 Group Homes, Outpatient & Day Treatment Facilities with a total of 14,542 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

A number of private group homes, outpatient & day treatment facilities voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2003 and ending June 30, 2004, these facilities reported 43 such deaths. Each of these reports was screened, and four were investigated. None of the deaths were due to restraint or hold. These numbers were not included in the above table.

Private Facilities: Intermediate Care Facilities for the Mentally Retarded (ICF-MR)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Pitt	Forest Hills Group Home	1	1	
Total		**1**	**1**	**0**

NOTES:

1. There were 326 Private ICF-MR's with a total of 2,682 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

A number of private ICF-MR's voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2003 and ending June 30, 2004, these facilities reported eleven such deaths. Each of these reports was screened, and two were investigated. None of the deaths were due to restraint or hold. These numbers were not included in the above table.

Private Facilities: Psychiatric Hospitals[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Avery	Charles A. Cannon Memorial Hospital	1	1	
Catawba	Catawba Valley Medical Center	1	0	
Moore	First Health of the Carolinas Moore Regional Hospital	2	0	
Orange	UNC Hospitals	2	0	
Pitt	Pitt County Memorial Hospital	1	1	
Wake	Wake County Human Services Alcoholism Treatment Center	2	1	
Total		**9**	**3**	**0**

NOTES:

1. There were 51 Private Psychiatric Hospitals and Hospitals with Psychiatric Units with a total of 1,822 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

A number of private psychiatric hospitals voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2003 and ending June 30, 2004, these facilities reported eight such deaths. Each of these reports was screened, and five were investigated. None of the deaths were due to restraint or hold. These numbers were not included in the above table.

Private Facilities: Facilities not licensed in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[1]
Buncombe	Community Alternative of NC	1	0	
Cumberland	Cumberland County Mental Health Center-Adult Services	1	0	
Gaston	Area Mental Health, Adult Case Management Services	1	0	
Gaston	Gaston Recovery Center	1	0	
Guilford	Alcohol and Drug Services	1	0	
Lincoln	Lincoln Counseling Center	1	0	
New Hanover	Southeastern Center	1	0	
Person	Person Counseling Center	1	0	
Stanley	Piedmont Behavorial Health Care	1	0	
Wilkes	New River Behavioral Health Care	1	0	
Total		**10**	**0**	**0**

NOTES:

1. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

A number of private facilities that were not licensed voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2003 and ending June 30, 2004, these facilities reported 13 such deaths. Each of these reports was screened, and none were investigated. None of the deaths were due to restraint or hold. These numbers were not included in the above table.

DEATHS REPORTED BY STATE FACILITIES

The last two tables provide data submitted by State facilities. It should be noted that death reporting for State facilities is different than for private facilities. The Secretary of DHHS has directed State-operated facilities to report all deaths to the Division of Facility Services, regardless of circumstance. This directive was first issued in April 2000 and re-issued in March 2001.

The following two tables for State facilities include all deaths, regardless of circumstances. For comparison with private facilities, summary information about the number of deaths that were subject to G.S. 122C-31 reporting requirements (e.g. occurred within seven days of restraint,

physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide) are provided below each table.

State Facilities: All Deaths Reported in State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF-MR)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Buncombe	Black Mountain Center	12	0	
Burke	J. Iverson Riddle Developmental Center	1	1	
Granville	Murdoch Center	9	0	
Lenoir	Caswell Center	18	0	
Wayne	O'Berry Center	3	0	
Total		**43**	**1**	**0**

NOTES:

1. There were 5 State-Operated ICF-MR's with a total of 1,903 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

The above table includes all deaths, regardless of circumstance. None of the above reported deaths were subject to G.S. 122C-31 reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide), and none of the deaths were due to restraint or hold.

State Facilities: All Deaths Reported in State-Operated Psychiatric Hospitals[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Burke	Broughton Hospital	10	5	
Granville	John Umstead Hospital	3	1	
Wake	Dorothea Dix Hospital	9	2	
Wayne	Cherry Hospital	5	2	
Total		**27**	**10**	**0**

NOTES:

1. There were 4 State-Operated Psychiatric Hospitals with a total of 1,263 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

The above table includes all deaths, regardless of circumstance. None of the deaths were due to restraint, physical hold, or seclusion. Three of the above reported deaths were subject to G.S. 122C-31 reporting requirements. Two of these were reported by Cherry Hospital (one occurred within seven days of restraint/seclusion, and one was the result of suicide), and one was reported by Broughton Hospital (the result of an accident).

For the death that occurred within seven days of restraint/seclusion, the individual involved apparently had a heart attack while in seclusion. The individual was taken to Wayne Memorial Hospital and died the next day. While the death was not due to the restraint/seclusion, non-

compliances were cited. Concerns were noted regarding the amount of thorazine that may have been given and the adequacy of monitoring while in seclusion.

TOTAL DEATHS

In all, a total of 108 private facilities and nine State facilities reported one or more deaths for the time period beginning July 1, 2003 and ending June 30, 2004.

A total of 256 deaths were reported by private facilities. Of this number, 128 were subject to statutory reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide). The other 128 were voluntarily reported. They were due to other causes and were not subject to statutory reporting requirements. A total of 70 deaths were reported by State facilities. Of this number, 24 were subject to statutory reporting requirements, and 46 were not subject to statutory reporting requirements. All deaths were screened. Approximately one-third (31%) of these were investigated. One death occurred within seven days of restraint, physical hold, or seclusion. None of the deaths were found to be the result of restraint, physical hold, or seclusion. Blank copies of the death reports used by facilities are included as **Attachment A: Report of Deaths** (for licensed assisted living and psychiatric inpatient facilities) and **B: Incident Death Form** (for all remaining facilities).

FACILITY COMPLIANCE WITH RESTRAINTS AND SECLUSION

Session Laws 2000-129 and 2003-80 also require the Department to report each year on facility compliance with restraint and seclusion policies. The data in this section were collected from on-site investigations, inspections and monitoring visits conducted by Department staff.

Separate tables are provided showing the number of restraint, physical hold, and seclusion related citations, by facility, for each type of facility, for the time period beginning July 1, 2003 and ending June 30, 2004. Additional data analysis is provided at the end of this section indicating the areas of highest and lowest non-compliance for each type of facility.

In reviewing the tables below, please note that the compliance data do not reflect all facilities. Rather, the data are limited to those facilities that warranted an on-site visit by Department staff. These visits include State survey and deficiency follow-up visits, complaint investigations, and change-of-ownership surveys. If a facility is not listed in the following tables, a citation for non-compliance with restraint/seclusion policies was not made.

Private Facilities: Licensed Assisted Living Facilities

County	Facility	# Citations
Buncombe	Marjorie McCune Memorial Center	22
Caswell	G. Anthony Rucker Rest Home	2
Craven	Croatan Village	15
Cabarrus	Cabarrus House	2
Cumberland	Wade Assisted Living	24
Rutherford	Haven-n-Hills Living Center	8
New Hanover	Oakdale Heights	3
Franklin	Zollieville Rest Home	6
Total		**82**

Private Facilities: Group Homes, Outpatient and Day Treatment Facilities

County	Facility	# Citations
Alamance	Hilford Residential Treatment Facility	1
Bertie	Guiding Light Home	1
Buncombe	Dogwood Court Home	2
	Eliadah School/Cummings Cottage	2
	Johnson Drive Home	2
Cabarrus	Ivy Lane Group Home	2
	Oakland House	2
Cherokee	The Crossing	2
	River House	2
Clay	Hayesville Group Home	2
Cleveland	HSS-WHISNATT Street	2
Craven	Wedgewood House	1
Cumberland	A Brighter Future	2
	Blue Place	1
	Brothers Helping Brothers	1
	Great Expectations Group Home	1
	Lakewood Treatment Facility	1
	Kemper Group Home	1
	New Faith Group Home	1
	Unlimited Destination #1	1
	(YCT)You Can Too #2	1
Forsyth	Community Assisted Residential Environment	1
Gates	Gates County	1
Guilford	Sudderth Manor	1
Harnett	People Achieving Living Skills	1
Lincoln	ALF	2
Lenoir	Old Farm House	1
McDowell	South Mountain Children's and Family Services	2
Mecklenberg	Alexander Children's Center	2
	The Shining Star Group Home #2	1
	Davis and Davis New Beginnings	2
	Keystone Charlotte LLC	4
Moore	Heather Trail	1
New Hanover	Eagles Nest Group Home	1
	New Hanover Day Treatment Center	1
Randolph	Heath House	1
	Hope's Care	1
Robeson	Cliffridge	1
	Holistic Services in Lumberton	1
Rowan	Therapeutic Resources	2
Stokes	Holly Valley Women's Division	1
Watauga	New River Respite	1
Wayne	Mt. Olive Group Home	1
Wilkes	Life Span Services-Wilkesboro	1
Total		**62**

Private Facilities: Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

County	Facility	# Citations
Cumberland	Northside Group Home	1
Burke	Lower Creek Group Home	2
Forsyth	Konoak Drive Group Home	1
Lincoln	Sunny Hill #1	1
Total		**5**

Private Facilities: Psychiatric Inpatient Facilities

County	Facility	# Citations
Alamance	Alamance Regional Medical Center	2
Beaufort	Beaufort County Hospital	2
Burke	Grace Hospital	2
Cabarrus	Northeast Regional	1
Catawba	Catawba Valley Medical Center	1
	Frye Regional Medical Center	2
Cumberland	Cape Fear Valley Medical Center	4
Davie	Thomasville Medical Center	3
Duplin	Duplin General Hospital	4
Durham	Duke University	4
	Durham Regional	10
Forsyth	Forsyth Hospital	3
	North Carolina Baptist Hospital	1
	Wake Forest Baptist Behavioral Health	2
Gaston	Gaston Memorial Hospital	1
Guilford	High Point Regional	2
	Moses Cone Hospital	1
Halifax	Halifax Regional Medical Center	3
Harnett	Good Hope Hospital	3
Henderson	Margaret Pardee Hospital	2
	Park Ridge Hospital	1
Herford	Roanoke Chowan Hospital	2
Iredell	Davis Medical Center	1
Johnston	Johnston Memorial Hospital	5
Mecklenburg	Carolinas Medical Center –Mercy	2
	Presbyterian Hospital	2
Moore	First Health Moore Regional	2
Nash	Nash General Hospital	2
New Hanover	New Hanover Regional Medical Center	2
Onslow	Brynn Marr Behavioral Health	9
Orange	UNC Hospitals	20
Pitt	Pitt County Memorial Hospital	3
Polk	St. Luke's Hospital	6
Richmond	Sandhills Regional Medical Center	3
Robeson	Southeastern Regional Hospital	2
Rowan	Rowan Regional Hospital	3
Rutherford	Rutherford Hospital	5
Stanley	Stanley Memorial Hospital	4
Wake	Holly Hill Hospital	9
Wayne	Wayne Memorial Hospital	3

Private Facilities: Psychiatric Inpatient Facilities (Continued)

County	Facility	# Citations
Wilson	Wilson Memorial	4
Total		**146**

The number of citations for psychiatric inpatient facilities was higher for the period 7/1/03 – 6/30/04 than 7/1/02 – 6/30/03. This occurred due to new restraint and seclusion regulations that became effective April 1, 2003. These regulations added documentation, training, and monitoring requirements. Many of the hospitals that were cited were unaware of the new requirements at the time that they were reviewed. When this trend was noted, the Department worked with the hospital association to ensure that hospitals became aware of these changes.

State Facilities: State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

County	Facility	# Citations
	No citations were issued	0
Total		**0**

State Facilities: State-Operated Psychiatric Hospitals

County	Facility	# Citations
Granville	John Umstead	2
Wayne	Cherry Hospital	5
Total		**7**

A total of 97 private facilities and two State-operated facilities were cited for non-compliance with one or more restraint/seclusion regulations for the time period beginning July 1, 2003 and ending June 30, 2004.

The following table provides an analysis of the most and least frequent areas of non-compliance. Percentages represent the percent of all citations for that type of facility. It should be noted that percentages for some non-compliances appear to be a large number when in fact there may have only been one non-compliance cited. This occurs in the case of facility types that had a low number of citations. For example, in the case of ICF-MR's, there were a total of five (5) citations issued. A single citation equates to 20% of the total. In contrast, in the case of group homes, outpatient and day treatment facilities, there were a total of 62 citations issued. In this case, a single citation equates to 1.6% of the total.

Facility Type	Areas of Non-Compliance	
	Most Frequent	**Least Frequent**
Licensed Assisted Living Facilities	• Inadequate restraint orders (29%) • Inadequate assessment and care planning (27%) • Inadequate documentation of restraint use (22%)	• Failure to check and release restraint within required time frame (10%) • Failure to have process to reduce restraint time by use of alternatives (10%)

Facility Type	Areas of Non-Compliance (Continued)	
	Most Frequent	**Least Frequent**
	• Failure to develop and implement policies and procedures (22%) • Inappropriate use of restraints (20%) • Failure to use alternatives prior to restraint use (15%) • Failure to obtain consent for restraint use from consumer/guardian (15%)	• Failure to train and validate staff competency prior to restraint use (7%) • Failure to use least restrictive restraint (7%) • Inappropriate use of restraints (5%) • Failure to document consent decision regarding restraint use (2%)
Group Homes, Outpatient and Day Treatment Facilities	• Failure to receive annual training on alternatives to restrictive interventions (31%) • Failure to receive annual training on restrictive interventions (15%) • Failure to receive any training on alternatives to restrictive intervention (10%) • Failure to demonstrate skills and competencies in restrictive interventions (10%) • Failure to receive any training in restrictive interventions (8%)	• Use of an unauthorized physical restraint technique (3%) • Failure to utilize least restrictive intervention (2%) • Failure to develop policies regarding the use and non-use of restrictive interventions (2%) • Failure to implement a positive and less restrictive technique before a more restrictive intervention (2%) • Failure to document a restrictive intervention (2%)
Private ICF-MR's	• Failure to keep a record of checks and usage of a restraint device (40%) • Failure to remove client from isolation/time-out room when started injuring self (40%)	• Implemented restraints without guardian consent and without including it in the treatment plan (20%)
Private Psychiatric Inpatient Facilities	• Inadequate restraint and seclusion monitoring and documentation (43%) • Inadequate restraint and seclusion policies and procedures (23%) • Restraints and seclusion not ordered properly, use not limited to emergency situations or as a planned measure of therapeutic treatment, used too much (14%)	• Inadequate notification (12%) • Inadequate training in restraint and seclusion (5%) • Inadequate restraint and seclusion room (3%)

Facility Type	Areas of Non-Compliance (Continued)	
	Most Frequent	**Least Frequent**
State Psychiatric Inpatient Facilities	• None in this category (none of the citations that were issued were listed more than once)	• Not getting appropriate orders for restraint (14%) • Lack of face-to-face assessment within one hour of restraint (14%) • Use of restraints not limited to emergency situations or as a planned measure of therapeutic treatment (14%) • Not using less restrictive alternatives before restraints (14%) • Lack of required restraints documentation (14%)

SUMMARY

In all, a total of 108 private facilities and nine State facilities reported one or more deaths for the time period beginning July 1, 2003 and ending June 30, 2004. This represents two percent (2.0%) of the 5,296 licensed private facilities and 100% of the nine State facilities.

A total of 256 deaths were reported by private facilities. Of this number, 128 were subject to statutory reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide). The other 128 were voluntarily reported. They were due to other causes and were not subject to statutory reporting requirements. A total of 70 deaths were reported by State facilities. Of this number, 24 were subject to statutory reporting requirements, and 46 were not subject to statutory reporting requirements. All deaths were screened. Approximately one-third (31%) of these were investigated. One death occurred within seven days of restraint, physical hold, or seclusion. None of the deaths were found to be the result of restraint, physical hold, or seclusion.

A total of 97 private facilities and two State-operated facilities were cited for non-compliance with one or more restraint/seclusion regulations during this same time period. This equates to 1.8% of the 5,296 licensed private facilities and 22.2% of the nine State facilities received a citation related to restraint/seclusion. Citations for non-compliance covered a wide range of areas from inadequate policies and procedures, documentation, and training, to inappropriate use of restrictive intervention, inadequate monitoring, and not first using a less restrictive alternative.

REPORT OF DEATH TO DHHS

All requested information must be provided. This form is for reporting resident deaths for all facilities operating under G.S. 131D-2. A resident's death occurring within seven days of physical restraint or physical hold of the resident, including death occurring within 24 hours of transfer to a hospital, must be reported immediately. All resident deaths resulting from accident, homicide, suicide or violence must be reported within three days of the death. If any requested information is unavailable, provide an explanation. The information must be provided immediately upon its availability. ■ *If additional space is needed,* attach separate sheets, referencing the part of the form to which the information pertains. ■ You may include additional information that you consider helpful, such as resident assessments and discharge summaries. ■ **(Please Note: Facilities are encouraged to keep a copy of the report for their records)**

***Submit form to*: Chief, Adult Care Licensure Section, Division of Facility Services, 2708 Mail Service Center, Raleigh, NC 27699-2708. Fax: (919) 733-9379; Phone: (919) 855-3765; Electronic Mail: barbara.ryan@ncmail.net.**

Section I: Reporting Facility

Name of reporting facility:	Medicare/Medicaid Provider # (if applicable):	Facility director:	Telephone:
Address:	License # :	First person to discover decedent:	Staff first receiving report of decedent's death:
	County:	Person (including title) preparing report:	Date/Time report prepared:

Section 2: Resident Information

Name of decedent:	Resident Record # (if applicable):	Unit/Ward (if applicable):	
	Medicare/Medicaid No (if applicable):	Date of Birth:	Age:
Admitting diagnoses:	Adjudicated incompetent: ☐ Yes ☐ No	Weight (if known):	Race:
	Date(s) of last two (2) medical exams (if known):	Height (if known):	Sex:

Date of most recent admission to a State operated psychiatric, developmental disability or substance abuse facility (if known):	Date of most recent admission to an acute care hospital for physical illness (if known):
Primary/secondary mental illness, developmental disability, or substance abuse diagnosis (if applicable):	Primary/secondary physical illness/conditions diagnosed prior to death:

Section 3: Circumstances of Death

Place where decedent died:	Date and time death was discovered:	
Address:	Physical location decedent was found:	
	Cause of death (if known):	

Was decedent "restrained" at the time of death or within 7 days of death including a death that occurred within 24 hours of transfer or discharge to a hospital?

☐ Yes ☐ No If "yes," describe type and usage:

Describe events surrounding the death:

Section 4: Other Information

Please list other authorities (such as law enforcement or the County Department of Social Services) that have been notified, have investigated or are in the process of investigating the death or events related to the death:

Critical Incident and Death Reporting Form

Client Name:_____ **Client Social Security No:** _____ - ____ -_____ **Client ID No:**_____

This form is used to report critical incidents and deaths for any person receiving mental health, developmental disabilities and/or substance abuse (mh/dd/sa) services. Facilities licensed under G.S. 122C (except hospitals) and unlicensed providers of periodic or community-based mh/dd/sa services must submit the form. Failure to complete this form, as required by North Carolina Administrative Code 10A NCAC 27G .0600, may result in administrative actions being taken against the provider's license or enrollment. **NOTE: Effective July 1, 2003, this form also replaces the Report of Death to DHHS Form for reporting deaths from unnatural causes.**

Instructions: Complete and submit this form within 72 hours of a critical incident or death. ♦ In addition, report immediately deaths that occur within 7 days of restraint or seclusion of a client to NC Division of Facility Services. ♦ Complete one form for each client and submit to the host and home area authorities/county programs. ♦ If requested information is unavailable, provide an explanation on the form and report the additional information as soon as it becomes available.

PROVIDER INFORMATION

Host area authority/county program:_____

Provider name:_____ Unit, ward or group home *(if applicable)*:_____

Address:_____ City:_____ County_____

Director / CEO:_____ Phone Number:_____

Provider Medicaid Number:_____ Facility License Number *(if applicable)*:_____

Name & title of first staff person to learn of incident _____

CLIENT INFORMATION

Date of incident: ____/____/____ Time of incident: ___: ___ ☐ a.m. ☐ p.m. Client Medicaid Number: _____

Client Date of Birth: ___/___/____ Client Gender: ☐Male ☐Female Weight:____lbs *(for deaths)* Height:____ft ____in *(for deaths)*

Client Ethnicity (*Check all that apply*)

☐ White ☐ Hispanic/Latino ☐ Black/African American

☐ Asian ☐ Native American ☐ Other *pecify)*:_____

All mh/dd/sa diagnoses: _____

_____

_____

Client's home area authority/county program *(if different from above)*:_____

Was the client treated by a physician for the incident? ☐ Yes ☐ No Date of treatment: _____/_____/_____

TYPE OF INCIDENT

DEATH

(Check only one)

Client death due to:

☐ Terminal illness or other natural cause

☐ Unknown cause

☐ SUICIDE

☐ ACCIDENT

☐ HOMICIDE / VIOLENCE

FOR ANY DEATH UNDERLINED ABOVE:

Complete the *Reportable Deaths* section, Page 2 *and* mail or fax a copy of this entire form to DFS Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077

ABUSE, NEGLECT, OR EXPLOITATION

(Check all that apply)

☐ Alleged abuse of a client.

☐ Alleged neglect of a client.

☐ Alleged exploitation of a client.

Verbally report any suspected case of abuse, neglect or exploitation of a consumer to the county Dept. of Social Services.

INJURY REQUIRING TREATMENT BY PHYSICIAN

(Check only one)

☐ Suicide attempt.

☐ Injury from use of a hazardous substance.

☐ Self-injury.

☐ Injury caused by another client.

☐ Other accident or injury.

MEDICATION ERRORS

Report medication errors that cause discomfort or that place a client in jeopardy

(Check only one)

☐ Missed dose of prescription medication.

☐ Wrong dosage administered.

☐ Wrong medication administered.

OTHER INCIDENTS

(Check all that apply)

☐ Client absence without notification for more than 3 hours.

☐ Suspension of a client from services.

Number of days suspended: _____

☐ Expulsion of a client from services.

☐ Arrest of a client for violations of state, municipal, county or federal law.

☐ Fire or equipment failure that has resulted in death or injury.

RESTRAINT & SECLUSION

Was the client restrained or in seclusion at the time of the incident? ☐ Yes ☐ No If yes, check applicable boxes below.

☐ Physically Restrained ☐ Chemically Restrained ☐ In Seclusion Duration: _____hours _____minutes

Only restraint or seclusion that results in abuse, neglect, injury or death needs to be reported on this form. However, all use of restraint or seclusion must be documented in the client's record, as required by the North Carolina Administrative Code. Providers using a standardized restraint & seclusion form are encouraged to submit that document with this form.

Did death occur within 7 days of restraint or seclusion of the client? ☐ Yes ☐ No

FOR ANY DEATH THAT OCCURS WITHIN 7 DAYS OF RESTRAINT OR SECLUSION, ***complete the Reportable Deaths section on Page 2 and immediately mail or fax a copy of this entire form to the DFS Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077***

Critical Incident and Death Reporting Form

Client Name:_____ **Client Social Security No:** _____ - ____ -_____ **Client ID No:**_____

REPORTABLE DEATHS

Complete only for deaths from suicide, accident, homicide, or violence or deaths occurring within 7 days of restraint or seclusion.

Address where client died: _____

Dates of last two (2) medical exams *(if known)*: _____/_____/_____ _____/_____/_____ Adjudicated incompetent?

Date of most recent admission to a state mh/dd/sa facility *(if known)*: _____/_____/_____ ☐ N/A ☐Yes ☐No

Date of most recent admission to a hospital for physical illness *(if known)*: _____/_____/_____ ☐ N/A

Physical illnesses/conditions diagnosed prior to death: _____

(attach additional pages as needed)

CIRCUMSTANCES OF INCIDENT

LOCATION OF INCIDENT

☐Provider premises ☐Client legal residence ☐School ☐Workplace ☐Community

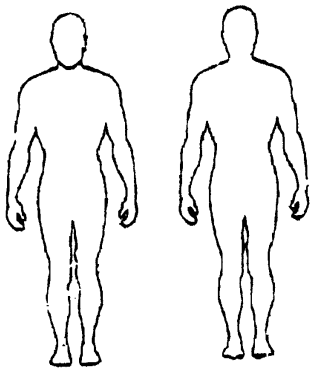
☐Other *(specify)* _____

DESCRIPTION OF INCIDENT

Include who (both participants and witnesses), what, why, and any other relevant information. ***(Attach additional pages if needed.)***

INJURY

On the figures below, circle the location of any bruises, cuts, scratches, injuries, or other marks that occurred as a result of the incident.



FRONT BACK

INTERNAL RESPONSE

Describe any investigation done to determine the cause of the incident and projected date of completion. If investigation is not completed or necessary, explain why ***(attach additional pages as needed)*****:**

Describe any corrective measures that have been or will be put in place as a result of the incident and person(s) responsible for ensuring implementation ***(attach additional pages as needed)***:

Indicate other authorities or persons that have been notified of the incident ***(where applicable)***:

☐ County DSS Contact Name: _____ Date ____/____/____

☐ Law enforcement Contact Name: _____ Date ____/____/____

☐ Case Manager Contact Name:_____ Date ____/____/____

☐ Client's Home Area Program Date ___/___/___ ☐ DFS Mental Health Licensure & Certification Section Date ____/____/____

☐ Parent / Guardian Date ___/___/___ ☐ DFS Health Care Personnel Registry Date ____/____/____

☐ Other _____ Date ____/____/____

Name & title of person preparing report *(Please print)*:_____

Signature _____ Date _____/_____/_____ Time ____:____ ☐ a.m. ☐ p.m.

Confidentiality of client information is protected. Use this form according to confidentiality requirements in NC General Statutes and Administrative Code and in the Code of Federal Regulations.

Direct any questions to: DMH/DD/SAS Accountability Team Phone: (919) 881-2446 FAX: (919) 881-2451

Send all forms by mail, fax or protected email within 72 hours of incident to the host and home area authorities/county programs.

For reportable deaths, also send a copy of the entire form to the DFS Mental Health Licensure and Certification Section, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077